

**U.S. Department of Labor**

Office of Administrative Law Judges  
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**Issue Date: 30 November 2004**

Case Nos.: 2002-BLA-0209  
2002-BLA-5114

In the Matter of:

RALPH E. CLARK, Deceased Miner, and  
KATIE LUCILLE CLARK, Widow,  
Claimants

v.

PEABODY COAL COMPANY,  
Employer

and

DIRECTOR, OFFICE OF WORKERS'  
COMPENSATION PROGRAMS,  
Party-in-Interest

BEFORE: Robert L. Hillyard  
Administrative Law Judge

DECISION AND ORDER - AWARD OF BENEFITS IN MINER'S CLAIM  
AND  
DENIAL OF BENEFITS IN SURVIVOR'S CLAIM

This proceeding arises from claims filed by Ralph E. Clark, Deceased, for living miner benefits, and by Katie L. Clark for survivor's benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901, *et seq.*, as amended ("Act"). In accordance with the Act, and the regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of persons who were totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising out of coal mine employment, and is commonly known as black lung.

Each of the parties has been afforded full opportunity to present evidence and argument as provided in the Act and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

The findings and conclusions that follow are based upon a careful analysis of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent case law.

### I. Statement of the Case

The Miner, Ralph E. Clark, filed a claim for black lung benefits pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, on February 25, 1999 (DX 1).<sup>1</sup> The District Director, OWCP, made an initial determination of nonentitlement (DX 35). The Claimant requested a formal hearing and the claim was referred to the Office of Administrative Law Judges on January 19, 2000 (DX 42).

A hearing on the Miner's claim was scheduled for June 13, 2001. On May 18, 2001, Katie Lucille Clark, wife of the Miner, advised that her husband had died on April 25, 2001. Mrs. Clark requested that his claim be remanded to the District Director to be consolidated with her May 15, 2001, survivor's claim (DX 1A). The request to remand for consolidation was granted by Order dated May 30, 2001. The Miner's claim was remanded and consolidated with the Survivor's claim. The District Director reviewed the Miner's claim under modification procedures and found that the additional evidence submitted on modification demonstrated a mistake in determination of fact and awarded benefits (DX 55). The Employer appealed and the Miner's claim is now before the undersigned on a request for modification by the Employer.

Mrs. Clark, the Miner's Widow, filed a Survivor's claim on May 15, 2001 (DX 1A). The Director issued a Proposed Decision and Order awarding benefits on January 9, 2002 (DX 30A). The Employer appealed and the claim was forwarded together with the Miner's claim on April 19, 2002 (DX 35A).

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<sup>1</sup> In this Decision, "DX" refers to the Director's Exhibits from the living miner's claim, "DX" followed by a number and "A" refers to the Director's Exhibits from Mrs. Clark's survivor's claim, "CX" refers to the Claimant's Exhibits, "LM EX" refers to the Employer's Exhibits in the living miner's claim, and "EX" refers to the Employer's Exhibits in the survivor's claim.

A formal hearing was scheduled for Terre Haute, Indiana, on February 18, 2004. At the parties' request, the hearing was cancelled and their motion for a decision on the record was granted. The record was held open until September 2, 2004, for the filing of additional evidence. The record was held open until October 6, 2004, for the filing of briefs. Briefs have been filed by both parties and have been considered in this Decision.

## II. Issues<sup>2</sup>

The issues as listed on Form CM-1025 are:

1. Whether the Miner has pneumoconiosis as defined by the Act and the regulations (Miner's and Survivor's claims);
2. Whether the Miner's pneumoconiosis arose out of coal mine employment (Miner's and Survivor's claims);
3. Whether the Miner was totally disabled (Miner's claim);
4. Whether the Miner's disability or death was due to pneumoconiosis (Miner's and Survivor's claims);
5. Whether the evidence establishes a change in conditions and/or that a mistake was made in determination of fact in the prior denial per § 725.310 (Miner's claim); and,
6. The remaining issues set forth in paragraph 18, as well as the issues as to constitutionality of the Act and its regulations are preserved for appeal purposes.

## III. Findings of Fact and Conclusions of Law

The Miner, Ralph E. Clark, was born on February 18, 1916, and died on April 25, 2001, at the age of 85 (DX 1, 1A). He had a high school education (DX 1). Mr. Clark had one dependent for purposes of augmentation of benefits; namely, his wife,

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<sup>2</sup> In its closing brief, Employer withdrew the issues of timeliness, miner, post-1969 employment, dependency, insurance, and responsible operator in both claims (pp. 49-50). The Employer conceded 35 years of coal mine employment (*Id.*).

Katie Lucille Clark, whom he married on July 25, 1941 (DX 1; DX 7). Mrs. Clark has not remarried.

Mrs. Clark testified that her husband smoked less than one-half pack of cigarettes per day from approximately 1937-1966 (29 years). Mrs. Clark said she was a light smoker and quit in the early 1980's (CX 3). This smoking history was corroborated by Mr. Clark's daughter, Judith Hale (CX 4). The examining physicians recorded similar smoking histories. Based on the testimony of Mrs. Clark, Mrs. Hale, and the physicians' reports, I find that Mr. Clark had a smoking history of approximately one-half pack of cigarettes per day for approximately 29 years, quitting in 1966, and that he was exposed to some undetermined amount of second-hand smoke from Mrs. Clark's smoking habit, as stated in the doctor's reports, until she quit in the early 1980's.

#### Coal Mine Employment

The determination of length of coal mine employment must begin with § 725.101(a)(32)(ii), which directs an adjudication officer to determine the beginning and ending dates of coal mine employment by using any credible evidence.

On his application, the Miner stated that he worked in coal mine employment for 35 years (DX 1). In its closing brief, the Employer conceded 35 years of coal mine employment (Em. Brief p. 49). The Miner's employment history lists coal mine employment from 1945-1953 and from 1957-1982 (DX 2). Mr. Clark's FICA Earnings worksheet shows coal mine employment from 1945-1953 and from 1958-1984 (CX 6). Based on the above evidence and Employer's concession, I find that 35 years of coal mine employment have been established. On his employment history, Mr. Clark stated that over the relevant period he was a unit boss or a mine inspector (DX 2).

Mrs. Clark submitted the affidavit of Joe Batson, the Director of Mines and Mining Safety for the State of Indiana (CX 5). He stated that the position of Mine Inspector requires consistent use of a tool belt adorned with approximately 30 pounds of tools. The job requires a great deal of walking while wearing the tool belt traversing rugged conditions, including loose rock on the floor and walking in a bent-over position in low areas. He stated that much of the time spent as an inspector is inside operating mines, and that during those times, an inspector receives similar coal dust exposure to coal miners.

Claimant's last employment was in the State of Indiana; therefore, the law of the Seventh Circuit is controlling.

#### Responsible Operator

Peabody Coal Company has withdrawn its challenge to the issue of responsible operator, and I find that Peabody Coal Company is properly named as responsible operator pursuant to §§ 725.494, 725.495.

#### IV. Medical Evidence

On September 1, 2004, the Employer filed a Motion requesting that the evidence developed in each claim be admitted in the other claim pursuant to 29 C.F.R. § 18.11. The Claimant responded and agreed that consolidation of evidence was appropriate in both claims. By Order dated September 21, 2004, the undersigned granted the parties' request to consolidate evidence under 29 C.F.R. § 18.11 and found good cause for exceeding the evidentiary limitations of § 725.414 in the survivor's claim. See *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-\_\_\_, BRB Nos. 03-615 BLA and 03-615 BLA-A (June 28, 2004) (*en banc*) (citing 20 C.F.R. § 725.456(b); 65 Fed. Reg. 79920, 80000 (Dec. 20, 2000) (a party must "convince the administrative law judge that the particular facts of a case justify the submission of additional medical evidence")). All evidence is listed below and will be considered in the determination of each claim.

#### X-ray Studies

	<u>Date</u>	<u>Exhibit</u>	<u>Doctor</u>	<u>Reading</u>	<u>Standard</u>
1.	09/30/99	LM EX 5	Repsher B reader <sup>3</sup>	0/0	Fair/ Dark

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<sup>3</sup> A "B reader" is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. See 42 C.F.R. § 37.51(b)(2).

2. 9/30/99 LM EX 1 Perme 0/0 Good  
B reader  
Board cert.<sup>4</sup>

Comments: Upper zone emphysema; right lobe mass, lung cancer?

3. 9/30/99 LM EX 1 Meyer 0/0 Good  
B reader  
Board cert.

Comments: 3 cm opacity in medial right base suspicious for bronchogenic carcinoma; severe emphysema.

4. 9/30/99 LM EX 1 Shipley 0/0 Good  
B reader  
Board cert.

Comments: No cwp; ? malignancy right lobe; compare to new/old films to rule out lung cancer.

5. 9/30/99 DX 42 Wiot 0/0 Good  
B reader  
Board cert.

Comments: Emphysema; density at right base.

6. 09/30/99 DX 40 Spitz 0/0 Good  
B reader  
Board cert.

Comments: Opacity in right lower lung.

7. 09/30/99 DX 34 Selby 0/0 Good  
B reader

8. 09/30/99 DX 27A Sargent 0/0 Good  
B reader  
Board cert.

9. 9/30/99 LM EX 6 Renn No pneumo Good  
B reader

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<sup>4</sup> A Board-certified Radiologist is a physician who is certified in Radiology or Diagnostic Roentgenology by the American Board of Radiology or the American Osteopathic Association. See § 718.202(a)(ii)(C).

10.	03/30/99	DX 31	Spitz	0/1 q/t	Good
			B reader		
			Board cert.		
11.	03/30/99	DX 30	Perme	0/0	Good
			B reader		
			Board cert.		
12.	03/30/99	DX 29	Shipley	0/0	Good
			B reader		
			Board cert.		
13.	03/30/99	DX 27	Wiot	0/0	Good
			B reader		
			Board cert.		
14.	03/30/99	DX 27	Meyer	0/0	Good
			B reader		
			Board cert.		
15.	03/30/99	DX 17	Kattan	1/1 p/q	Good
			B reader		
			Board cert.		
16.	03/30/99	DX 16	Sargent	0/0	Good
			B reader		
			Board cert.		
17.	03/30/99	DX 15	Cappiello	1/2 s/q	Fair
			B reader		
			Board cert.		
18.	03/30/99	LM EX 5	Repsher	0/0	Good
			B reader		
19.	03/30/99	LM EX 6	Renn	No pneumo	Good
			B reader		

#### Pulmonary Function Studies

	<u>Date</u>	<u>Ex.</u>	<u>Doctor</u>	<u>Age/Hgt<sup>5</sup></u>	<u>FEV<sub>1</sub></u>	<u>MVV</u>	<u>FVC</u>	<u>Standards</u>
1.	09/30/99	DX 34	Selby	83/66"	1.60	62	3.09	Tracings
				Post-				included/
				Bronch.	1.76	64	3.21	coop./comp.
								not noted

<sup>5</sup> The factfinder must resolve conflicting heights of the Miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find the Miner's height to be 67".

2.	03/30/99	DX 11	Carandang	83/68"	1.52	59	3.09	Tracings
				Post-				included/
				Bronch.	1.75	64	3.22	Good coop.
								/comp.

Dr. Katzman validated the results of this test (DX 12).

#### Arterial Blood Gas Studies

	<u>Date</u>	<u>Exhibit</u>	<u>Physician</u>	<u>pCO<sub>2</sub></u>	<u>pO<sub>2</sub></u>
1.	09/30/99	DX 34	Selby	39.0	78.0
2.	03/30/99	DX 14	Carandang	43.7	96.1
			Exercise	46.3	77.9

Dr. Renn opined that the Miner's 96.1 pO<sub>2</sub> reading was abnormally high and may have been caused by testing right after the Miner stopped his supplemental oxygen, thereby producing an artificially high reading (LM EX 8).

Dr. Tuteur stated that the resting pO<sub>2</sub> reading is biologically impossible because it reflects that the Miner's body was secreting oxygen instead of absorbing it (LM EX 13).

#### Narrative Medical Evidence

1. Dr. Renaldo Carandang, a Board-certified Internist, examined the Claimant on March 30, 1999 (DX 13). Based on symptomatology (sputum, wheezing, dyspnea, cough, chest pain, orthopnea, ankle edema, paroxysmal nocturnal dyspnea), employment history (33 years coal mine employment), individual and family histories (chronic bronchitis, hernia, stroke, colon cancer), smoking history (30 years, 1/3 pack per day), physical examination (short of breath, few expiratory wheezes, basal rales), chest x-ray, pulmonary function study, and an arterial blood gas study, Dr. Carandang diagnosed coal workers' pneumoconiosis, COPD, and ASCVD. He listed the etiology of the pneumoconiosis as coal dust. He attributed the COPD to cigarette smoke and the ASCVD to atherosclerosis. He opined that the Miner could no longer perform his last mining job.

2. Dr. Robert A.C. Cohen, a Board-certified Internist, Pulmonologist, Critical Care Specialist, Medical Examiner, and a B reader, performed an April 15, 2004 records review at the request of the Claimant (CX 1). He reviewed all record evidence including pathology reports and opined that Mr. Clark did suffer from coal workers' pneumoconiosis. He based his opinion on a long work history of coal mine employment, symptomatology

reported to the various physicians, physical examination findings which included wheezes, rales, crackles, and rhonci, pulmonary function results, and autopsy findings. Dr. Cohen then discussed an extensive list of medical literature reviewing the connection between pulmonary obstruction and coal dust exposure. He opined that Mr. Clark had chronic obstructive lung disease with a minor reversible component. He disagreed with Dr. Renn's and Dr. Selby's opinion that a component of Mr. Clark's lung disease may be asthma related. He opined that with an FEV<sub>1</sub> rating of only 65% of predicted on the September 1999, pulmonary function study, and diffusion capacity of only 38% of predicted, Mr. Clark would be totally disabled from his job as a mine inspector, a position which would require him to carry 30 pounds of tools while walking and occasionally crawling. Dr. Cohen opined that the medical literature reviewed "clearly shows a strong relationship between the development of emphysema, chronic bronchitis and coal mine dust exposure. Mr. Clark's coal mine dust exposure was much more important than his modest exposure to tobacco smoke in the development of his emphysema and chronic obstructive lung disease." He then listed his disagreements with Drs. Selby, Tuteur, Renn, and Repsher.

3. Dr. John E. Parker, a Board-certified Internist, Pulmonologist, Medical Examiner, and a B reader, performed a records review at the request of the Claimant on April 12, 2004 (CX 2). After review of the medical evidence, including autopsy reports, Dr. Parker opined that the Miner suffered from pneumoconiosis. He based his opinion on clinical evaluations of the chest, radiographic evidence, pulmonary function testing, and autopsy evidence. He opined that Mr. Clark's pneumoconiosis and COPD were totally disabling and that Mr. Clark would be unable to perform his last position as a mine inspector, as he no longer retained the pulmonary capacity to carry 30 pounds of tools while walking on uneven terrain in coal mines. He opined that Mr. Clark's respiratory impairment, from his pneumoconiosis and COPD, "was caused in substantial part by both his over 25 years of coal mine dust exposure, ending in 1985 and by his not more than 15 pack years of smoking history ending not later than 1974." He discussed several medical articles which he stated showed that miners experience an excess of chronic obstructive pulmonary disease caused by coal mine dust. He acknowledged the well-documented relationship between cigarette smoking and COPD, and opined that "in Mr. Clark's case we have a substantial history of both [cigarette smoke and coal dust] assaults upon his lungs."

4. a. Dr. Joseph J. Renn, a Board-certified Internist, Pulmonologist, Forensic Examiner, a Forensic Medicine Specialist, and a B reader, performed a March 5, 2001, records

review at the request of the Employer (LM EX 6). Dr. Renn noted varying smoking histories ranging from one-half pack of cigarettes per day for 12 years to 2 packs of cigarettes per day for 30 years. The records further reflect that Mr. Clark was exposed to second-hand smoke from his wife. Dr. Renn reviewed all record evidence in the Miner's claim and opined that pulmonary function tests, after review for validity, showed a moderate, significantly bronchoreversible obstructive ventilatory defect. Arterial blood gases were normal at rest, but exercise gas exchange reveals impairment in gas exchange. The vast majority of x-rays showed changes consistent with pulmonary emphysema and the absence of changes consistent with pneumoconiosis. CT scans showed emphysema with no changes consistent with pneumoconiosis. Dr. Renn opined that Mr. Clark suffered from chronic bronchitis and pulmonary emphysema "owing to his years of tobacco smoking." He opined that the Miner was totally disabled by chronic bronchitis and pulmonary emphysema from performing his previous job as a coal mine inspector or any similar work effort. He based his tobacco etiology on a significant smoking history, a lack of radiographic evidence of pneumoconiosis, CT scans showing emphysema, and the bronchoreversible nature of the Miner's obstructive defect.

b. Dr. Renn submitted a supplemental report dated May 21, 2004, in which he discussed the opinions of Drs. Cohen and Parker (LM EX 12). Dr. Renn stated that Dr. Cohen had misstated the findings of Dr. Renn's earlier report. Dr. Renn took issue with the medical studies relied on by Dr. Cohen. He stated that some of the data used in the Marine study was defective, that other studies not used by Dr. Cohen more effectively discussed the issues at hand, and that Dr. Cohen drew inappropriate conclusions from the medical literature cited. Dr. Renn supported his opinion with other medical literature which conflicted with Dr. Cohen's analysis.

c. Dr. Renn was deposed on April 17, 2003, when he repeated his earlier findings (LM EX 8).<sup>6</sup> He opined that if pathologic evidence later showed simple coal workers' pneumoconiosis where CT scans did not pick it up, such pneumoconiosis would be clinically insignificant and would not produce recordable symptoms or respiratory impairment.

d. Dr. Renn was deposed a second time on April 17, 2003, to discuss causation of the Miner's death (EX 5). He

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<sup>6</sup> The Employer took two separate depositions of Drs. Renn and Tuteur on the same day. The first deposition was devoted to the Miner's claim; the second deposition was devoted to the Widow's claim. Each deposition covers separate subject matter and each deposition was submitted and admitted with distinct Exhibit Numbers.

stated that pathology records showed that Mr. Clark did suffer from coal workers' pneumoconiosis. He reconciled that finding with his earlier finding of no pneumoconiosis by explaining that sometimes coal workers' pneumoconiosis is so mild that it has not yet reached the stage where it can be detected by the very best noninvasive clinical methods including x-rays and CT scans. "In those cases, the coal workers' pneumoconiosis is so mild that it hasn't reached the stage of being able to cause any impairment of ventilatory function." He opined that Mr. Clark did not die a respiratory death. He died of overlapping cardiac-related problems. He disagreed with Dr. Nehren, stating that many of her assumptions and diagnoses were based on false facts, including her diagnosis of restrictive lung disease, hypoxia, and a documented need for supplemental oxygen. He opined that Mr. Clark's death was not caused or hastened in any manner by coal workers' pneumoconiosis or pulmonary disease.

e. Dr. Renn was deposed a third time on June 18, 2004 (EX 15). He discussed additional medical literature and studies that he felt supported his findings and discussed his disagreement with the conclusions reached by Dr. Cohen.

5. a. Dr. Lawrence Repsher, a Board-certified Internist, Pulmonologist, Medical Examiner, Critical Care Specialist, and B reader, performed a February 22, 2001, records review at the request of the Employer (LM EX 5). He reviewed the record evidence in the Miner's claim and opined that smoking histories varied considerably from 12-30 years, that the majority of B readers found no radiographic evidence of coal workers' pneumoconiosis and were concerned about possible bronchogenic cancer. Pulmonary function testing showed moderate to moderately severe COPD without an immediate bronchodilator response and possibly some very mild impairment in diffusing capacity. Arterial blood gases were nonqualifying. He diagnosed no evidence of coal workers' pneumoconiosis or respiratory or pulmonary disease caused by or aggravated by coal mine employment. He diagnosed moderate to moderately severe COPD and emphysema, secondary to cigarette smoking. He diagnosed peripheral vascular disease, severe left CVA with residual right hemiparesis and progressive dementia, carcinoma of the colon, current status unknown, and possible bronchogenic cancer. He based his diagnosis of no pneumoconiosis on a lack of radiographic, pulmonary function, and arterial blood gas evidence of pneumoconiosis. He did not make a finding as to disability.

b. Dr. Repsher was deposed by the Employer on February 2, 2004, when he repeated the findings of his written report (LM EX 9). He opined that a review of autopsy evidence

since his last report demonstrated the existence of histologic simple coal workers' pneumoconiosis which produced no symptoms. He opined that the Miner suffered from rather marked COPD, serious enough to make performance of his job uncomfortable, but that he still retained the pulmonary capacity to perform his last coal mine job as a mine inspector. He characterized Mr. Clark's position as Chief Coal Mine Inspector for the State of Indiana as "pretty much a desk job with only occasionally going out in the field." "[H]e certainly had plenty of lung function even in 1999 that he could have done light work and certainly a desk job."

c. Dr. Repsher submitted a supplemental report dated May 13, 2004, in which he reviewed and commented on the reports of Drs. Parker and Cohen. He listed 10 specific reasons to discount the medical literature cited by Dr. Parker and/or the conclusions reached in reliance on those articles. "All of [the] conclusions are rendered invalid by numerous flaws in both design and the actual carrying out of each of these studies." He noted that many of the authors were not even physicians, and the ones who were physicians were not Pulmonologists or B readers. Most of the studies had high drop out rates resulting in selection bias. Most did not consider confounding diseases or smoking. Coal dust measurements and pulmonary function tests used in the earlier studies were hopelessly inaccurate. On review of Dr. Cohen's report, Dr. Repsher listed 14 similar flaws in the data cited by Dr. Cohen.

d. Dr. Repsher was deposed for a second time on May 25, 2004, when he discussed the findings of his May 13, 2004 written report (LM EX 14).

6. a. Dr. Jeff Selby, a Board-certified Internist, Pulmonologist, Critical Care Specialist, and B reader, examined the Claimant on September 30, 1999 (DX 34). Based on symptomatology (shortness of breath, cough, sputum), employment history, individual and family histories (past hernias, colon cancer, stroke), smoking history (difficult to understand, vague; one-half to one pack per day for 12 years), physical examination (poor memory, chest normal, no wheezes, rales, or rhonchi), chest x-ray (0/0), CT scan (no cwp), pulmonary function study (moderate obstructive lung defect), arterial blood gas study (normal), and an EKG, Dr. Selby diagnosed: no coal workers' pneumoconiosis or any pulmonary or respiratory abnormality as a result of previous coal mine employment or coal dust exposure based upon x-ray, CT scan, and physical examination; no total disability due to previous coal mine dust exposure based on physical examination, pulmonary function testing and arterial blood gases. Mr. Clark retains the ability

to perform his last work as a coal mine inspector. He has a moderate obstructive lung defect as a result of primary and secondary smoke exposure and possibly also in combination with bronchial asthma demonstrated by history and partial reversibility with bronchodilation. Mr. Clark suffers from self-reported chronic bronchitis unrelated to coal mine employment. He has numerous nonpulmonary medical problems including stroke, cardiac disease, colon cancer and past trauma.

b. Dr. Selby was deposed by the Employer on May 15, 2000, when he repeated the findings in his earlier written report (LM EX 4).

7. a. Dr. Jerome F. Wiot, a Board-certified Radiologist and a B reader, interpreted a September 30, 1999, CT scan (DX 42). He opined that it showed no evidence of coal workers' pneumoconiosis, but did show evidence of bullous change and diffuse overexpansion of the lungs consistent with emphysema.

b. Dr. Wiot was deposed by the Employer on May 5, 2000, when he repeated his x-ray interpretations and discussed his September 30, 1999, CT scan findings (LM EX 3).

8. a. Dr. Peter Tuteur, a Board-certified Internist and Pulmonologist, performed a April 17, 2000, records review at the request of the Employer (LM EX 2). On review of the record evidence in the Miner's claim, Dr. Tuteur opined that a majority of x-rays and all CT scans were interpreted as negative for pneumoconiosis. CT scans showed advanced bullous emphysema and possible malignancy in the right lower lobe. Pulmonary function studies showed a moderate obstructive defect, while arterial blood gases showed a dramatic fall in arterial oxygen tension during exercise. Based on these findings, Dr. Tuteur opined that there was no convincing evidence of coal workers' pneumoconiosis or any other coal mine dust-induced disease process. He opined that x-rays, symptomatology, physical examination reports, pulmonary function testing and CT scans confirm the presence of emphysema and advanced smoke-induced chronic obstructive disease. He supported his smoking etiology by reviewing the symptoms and their likely connection to clinically significant coal workers' pneumoconiosis. He reviewed physical examination reports and commented that the findings were inconsistent over time, and that the abnormal results, when reported, were not consistent with the irreversibility of the interstitial fibrosis of pneumoconiosis. He stated that pulmonary function studies showed a moderate obstructive ventilatory defect and impairment of gas exchange during exercise, which would prevent him from performing the work of a coal miner or work requiring similar effort.

b. Dr. Tuteur submitted a supplemental written report on July 8, 2002 (EX 1). On review of autopsy and hospitalization records submitted since his previous report, Dr. Tuteur opined that autopsy records confirmed the existence of very mild simple coal workers' pneumoconiosis and very severe centrilobular emphysema, severe chronic bronchitis, and myocardial infarctions in association with coronary artery disease. He stated that Mr. Clark's pneumoconiosis was of insufficient magnitude to produce radiographic abnormalities on either x-rays or CT scans. Pulmonary function evidence demonstrated no restriction and adequate gas exchange. There was no measurable impairment attributable to coal workers' pneumoconiosis. He then repeated his smoking etiology and the basis of his findings. He opined that a review of hospitalization records and autopsy findings showed that:

Mr. Ralph E. Clark died with and because of complications of arteriosclerotic heart disease, atrial fibrillation, congestive heart failure, peripheral vascular disease, and the acute development of gangrene, osteomyelitis, and renal failure, all leading to death. None of these conditions are in any way related to, aggravated by, or caused by the inhalation of coal mine dust or the development of coal workers' pneumoconiosis.

He then dedicated a page of his report to pointing out flaws and misstatements of facts made by Dr. Nehren.

c. Dr. Tuteur was deposed by the Employer on April 15, 2003, when he repeated the findings of his written reports (LM EX 7).<sup>7</sup> He further explained his meaning of clinically significant pneumoconiosis. He opined that because x-ray and CT scan evidence was negative, pulmonary function tests did not show a restrictive abnormality or impairment of gas exchange, and since physical examinations did not show persistent late inspiratory crackling sounds even though he was breathless, Mr. Clark may have had clinical pneumoconiosis that would show up on a microscopic examination of the lungs, but it did not produce any diagnosable or reportable symptoms. Dr. Tuteur noted that legal pneumoconiosis in the form of coal dust-produced COPD was also implausible. He opined that medical literature and studies conclude that COPD occurs in 15-25% of people with Mr. Clark's smoking history, but that the risk of contracting COPD from the Miner's level of coal dust exposure was less than 1%. Under those percentages, he opined that

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<sup>7</sup> See FN #6.

smoking was the logical etiology to draw from the data reviewed and the literature cited.

d. Dr. Tuteur was deposed for a second time on April 15, 2003, to discuss the Miner's death (EX 4). He reviewed the medical evidence of record (including the post-mortem report of Dr. Naeye), and opined that the Miner died of malnutrition and multi-organ failure in association with peripheral vascular disease, gangrene, and osteomyelitis. He opined that Mr. Clark did not die from a pulmonary cause. Although the autopsy showed mild coal workers' pneumoconiosis and mild chronic bronchitis, the Miner's pulmonary function testing and arterial blood gases were effectively normal when adjusted for the Miner's advanced age. He refuted Dr. Nehren's opinion as flawed and unreasoned. He pointed out that the objective data did not show restrictive lung disease as noted by Dr. Nehren. The Miner was never proven to be oxygen dependent, and normal arterial blood gas readings disprove any need for oxygen. The Miner was not shown to suffer from hypoxia. There was similarly no "history" of black lung disease documented for her to rely upon. Dr. Tuteur opined that her report was factually flawed and unreliable. He further opined that the Miner's last four hospitalizations showed no pulmonary problems whatsoever. He opined that there was no evidence in the record to support that Mr. Clark's death was caused by or hastened by coal workers' pneumoconiosis or any pulmonary condition related to coal mine employment.

e. Dr. Tuteur submitted a third written report on May 18, 2004, evaluating the opinions and reports of Drs. Parker and Cohen and evaluating the affidavits of Katie Lucille Clark, Judith Hale, and Joe Batson (LM EX 11). Dr. Tuteur discussed in detail his objections to each study cited by Drs. Cohen and Parker, including methodology problems and/or inappropriate conclusions drawn from the data collected in each article. He then related the studies cited in Dr. Cohen's report and offered what he opined to be better, more valid studies which contradict the conclusions reached by Dr. Cohen.

f. Dr. Tuteur was deposed a third time on May 25, 2004 (LM EX 13). He opined that there is "at least a ten-fold difference in the likelihood that [the Miner's obstructive defect] is due uniquely to cigarette smoke than to the inhalation of coal mine dust." He then reviewed the medical literature cited by Drs. Parker and Cohen and stated his disagreements with the studies cited or their interpretations by Drs. Parker and/or Cohen. He found that all of the studies that Drs. Cohen and Parker cited were either methodologically flawed

or drew conclusions that are not evident from the data presented.

9. Dr. Charles M. Perme, a Board-certified Radiologist and B reader, interpreted a September 30, 1999, CT scan (LM EX 1). He opined that the scan showed severe centrilobular and paraseptal emphysema, nodules suspicious for synchronous lung cancers, and no evidence of coal workers' pneumoconiosis.

10. Dr. Christopher A. Meyer, a Board-certified Radiologist and B reader, interpreted a September 30, 1999, CT scan (LM EX 1). He identified severe bilateral centrilobular emphysema, several larger opacities "which may represent post-inflammatory scarring or early neoplasm" probable left adrenal adenoma, and no evidence of coal workers' pneumoconiosis.

11. Dr. Thomas E. Schultheis, who presents no specialty credentials, interpreted a September 30, 1999, CT scan (DX 34). He identified bullous changes, hyperinflated lungs, central lobular bronchial thickening, and some interstitial prominence noted in right base.

12. Dr. Ralph T. Shipley, a Board-certified Radiologist and B reader, interpreted a September 30, 1999, CT scan (LM EX 1). He noted moderate to severe upper zone predominant emphysema, small speculated nodules present most likely representing healed granulomatous disease or malignancy, and no evidence of coal workers' pneumoconiosis.

13. Dr. Harold B. Spitz, a Board-certified Radiologist and B reader, interpreted a September 30, 1999, CT scan (DX 40). He opined that the scan showed emphysema with numerous bullae in the upper lobes; an opacity in the right lower lung; rib fracture; and no evidence of coal workers' pneumoconiosis.

14. a. Dr. Norma Nehren, the Miner's family physician and a Board-certified Family Practitioner, submitted an August 27, 2001, letter stating that Mr. Clark's oxygen dependence "came from severely restricted and obstructed lung disease, COPD exacerbated by a history of black lung disease."

b. Dr. Nehren submitted a July 3, 2001, letter (DX 13A). She opined that:

[h]is severe lung restriction secondary to chronic pulmonary disease aris[es] from his coal mine employment and [is] exacerbated by his history of exposure to coal mine dust. This significantly aggravated the conditions from which he died including

his chronic hypoxia and O<sub>2</sub> dependent, acute vascular disease and malnutrition experienced during his hospital stay as well as his ability to recover from pulmonary assault. I believe that the pneumoconiosis was a substantial re-contributing factor to this man's death although it does not appear to have been the direct cause.

15. The Miner's Certificate of Death (DX 8A), lists the immediate cause of death as malnutrition, due to or as a consequence of "black lung, COPD, inability to swallow." Other significant conditions contributing to death are illegible. The Certificate of Death was filled out by Dr. DuPre, one of the Miner's treating physicians.

16. Dr. Heidingsfelder, a Forensic Pathologist, performed the Miner's autopsy on April 26, 2001, reviewed 23 autopsy slides, and submitted two autopsy reports (DX 21A, 28A). Macroscopic review of the lungs showed marked anthracotic pigment deposition more or less diffusely over all pulmonary lobes. Evidence of moderate chronic bronchitis and emphysema are present. The cut sections of lung tissue revealed large and diffuse deposits of black coloration and nodules present in both lungs, primarily upper lobes. Macroscopic findings were consistent with coal workers' pneumoconiosis. Microscopic examination showed interstitial fibrosis consistent with coal workers' pneumoconiosis and emphysema.

17. Dr. Richard L. Naeye, a Board-certified Anatomic and Clinical Pathologist, performed a December 12, 2001, records review at the request of the Employer (DX 29A). He reviewed medical evidence of record from the living miner's claim and 23 autopsy slides, 19 containing lung tissue. On microscopic examination, most showed at least some anthracotic macules, micronodules and macronodules. He opined that:

The many anthracotic macules, micronodules and macronodules in this man's lungs are conclusive evidence of the presence of simple coal workers' pneumoconiosis. ... [I]t is unlikely that the CWP lesions in this man's lungs were numerous enough to have measurably affected lung function or caused disability. He was disabled in late years by heart and lung disorders caused by his many years of cigarette smoking. These disorders were centrilobular emphysema and chronic bronchitis. ... Ralph Clark's CWP lesions were too small and too few in number to have had a significant role in the genesis of either his disability or his death.

### Treatment Notes

Dr. Nawwar F. Mercho submitted letters dated June 8, 1998, October 26, 1998, and March 1, 1999, regarding the Miner's heart condition (DX 24A). On the June 8, 1998, and the October 26, 1998, examinations, he noted lungs were clear to auscultation. In a letter dated May 15, 1998, Dr. Mercho diagnosed "possible pneumoconiosis" based primarily on the Miner's self-report of dyspnea which Mr. Clark attributed to black lung from his working in the coal mine.

The record contains treatment notes from Dr. James R. Rohrer, II (DX 23A). Notes dated February 2, 1998, show bilateral rhonci. Notes dated February 5, 1998, showed that "his PFT's were terrible." Chest was "pretty clear today." Notes dated February 26, 1998, show Mr. Clark on home oxygen, chest clear. All treatment notes diagnose COPD and emphysema. None diagnose pneumoconiosis.

The record contains 89 pages of hospitalization records from Sullivan County Community Hospital where Mr. Clark died on April 25, 2001 (DX 22A). None of the records concerned pulmonary problems. There was no diagnosis of pneumoconiosis.

The record contains 319 pages of treatment notes from Good Samaritan Hospital in Vincennes, Indiana (DX 11A, EX 2). The notes state a "history of black lung." Lungs were clear on examination.

### V. Discussion and Applicable Law

Both the Living Miner and the Survivor's claims were filed after March 31, 1980, the effective date of Part 718. As such, both claims will be adjudicated under those regulations.<sup>8</sup>

Mr. Clark filed his claim for black lung benefits on February 25, 1999 (DX 1). His claim was filed before January 19, 2001, the effective date of the 2001 Amendments to Part 718. Therefore, it shall be considered under the pre-amendment regulations.

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<sup>8</sup> Amendments to the Part 718 regulations became effective on January 19, 2001. Section 718.2 provides that the provisions of § 718 shall, to the extent appropriate, be construed together in the adjudication of all claims.

Mrs. Clark filed her survivor's claim on May 15, 2001 (DX 1A). Her survivor's claim is subject to the amended regulations.

#### Miner's Claim

In order to establish entitlement to benefits in a living miner's claim pursuant to 20 C.F.R. § 718, the claimant must establish that the miner suffered from pneumoconiosis, that the pneumoconiosis arose out of coal mine employment, and that the pneumoconiosis is totally disabling. See 20 C.F.R. §§ 718.3, 718.202, 718.203, 718.204; *Peabody Coal Co. v. Hill*, 123 F.3d 412, 21 B.L.R. 2-192 (6<sup>th</sup> Cir. 1997); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986) (*en banc*).

#### Modification

Section 22 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 922, as incorporated into the Black Lung Benefits Act by 30 U.S.C. § 932(a), and as implemented by 20 C.F.R. § 725.310, provides that upon a miner's own initiative, or upon the request of any party on the grounds of a change in condition or because of a mistake in a determination of fact, the fact-finder may, at any time prior to one year after the date of the last payment of benefits or any time before one year after the denial of a claim, reconsider the terms of an award of a denial of benefits. Section 725.310(a). Because the Employer's request for modification was made within one year after the denial of this claim, the Employer's motion is timely and will be considered under the relevant regulatory provisions found at § 725.310.

In deciding whether a mistake in fact has occurred, the United States Supreme Court stated that the Administrative Law Judge has "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971). A "mistake in a determination of fact" includes mixed questions of law and fact, including the "ultimate fact" of whether the claimant is entitled to benefits under the Act. *Amax Coal Co. v. Franklin*, 957 F.2d 355, 358 (7<sup>th</sup> Cir. 1992).

In determining whether a change in condition has occurred requiring modification of the prior denial, the Board has similarly stated that:

... the administrative law judge is obligated to perform an independent assessment of the newly submitted evidence, considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish at least one element of entitlement which defeated entitlement in the prior decision.

*Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994). Furthermore,

if the newly submitted evidence is sufficient to establish modification ..., the administrative law judge must consider all of the evidence of record to determine whether the Claimant has established entitlement to benefits on the merits of the claim.

*Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156 (1990). Modified on recon., 16 B.L.R. 1-71 (1992).

The Director awarded benefits on modification because he found that newly submitted evidence showed a mistake in determination of fact and that the evidence established the existence of pneumoconiosis arising out of coal mine employment and total disability resulting from pneumoconiosis. The Circuit Courts and Benefits Review Board have held that, for purposes of establishing modification, the phrase "change in conditions" refers to a change in the claimant's physical condition. See *General Dynamics Corp. v. Director, OWCP*, 673 F.2d 23 (1<sup>st</sup> Cir. 1982); *Director, OWCP v. Drummond Coal Co.*, 831 F.2d 240 (11<sup>th</sup> Cir. 1987). As pneumoconiosis is an irreversible disease, there can be no showing of a change in conditions. That is, Mr. Clark cannot suddenly recover from an irreversible disease. I will review the evidence, old and new together, to determine whether a mistake in determination of fact was made in the prior decision establishing pneumoconiosis and awarding benefits.

#### Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under § 718.202(a)(1), a finding of pneumoconiosis may be made on the basis of x-ray evidence. The record contains nineteen interpretations of two different chest x-rays.

The Board has held that an Administrative Law Judge is not required to defer to the numerical superiority of x-ray evidence, *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-65 (1990), although it is within his or her discretion to do so, *Edmiston*

v. *F&R Coal Co.*, 14 B.L.R. 1-65 (1990). However, "administrative factfinders simply cannot consider the quantity of evidence alone, without reference to a difference in the qualifications of the readers or without an examination of the party affiliation of the experts." *Woodward v. Director, OWCP*, 991 F.2d 314 (6<sup>th</sup> Cir. 1993).

Interpretations of B readers are entitled to greater weight because of their expertise and proficiency in classifying x-rays. *Vance v. Eastern Assoc. Coal Corp.*, *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985); 8 B.L.R. 1-68 (1985). Physicians who are Board-certified Radiologists as well as B readers may be accorded still greater weight. *Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6<sup>th</sup> Cir. 1993).

The September 30, 1999, x-ray was read as negative by Drs. Perme, Meyer, Shipley, Wiot, Spitz, and Sargent, who are Board-certified Radiologists and B readers, and as negative by Drs. Repsher, Selby, and Renn, who are B readers. As there are no positive readings of this x-ray, I find that the September 30, 1999 x-ray is negative for pneumoconiosis.

The March 30, 1999, x-ray was read as negative by Drs. Spitz, Perme, Shipley, Wiot, Meyer, and Sargent, who are Board-certified Radiologists and B readers, and as negative by Drs. Repsher and Renn, both B readers. This x-ray was read as positive by Drs. Kattan and Cappiello, who are both Board-certified Radiologists and B readers. Noting comparable credentials, I afford more weight to the eight negative readings over the two positive readings, and I find that the March 30, 1999, x-ray evidence is negative for pneumoconiosis.

Having found each of the x-rays to be negative for pneumoconiosis, I find that the existence of pneumoconiosis has not been established pursuant to 20 C.F.R. § 718.202(a)(1).

A finding of pneumoconiosis may be made on the basis of biopsy or autopsy results under § 718.202(a)(2). Autopsy evidence is the most reliable evidence of the existence of pneumoconiosis. *Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985); *Peabody Coal v. McCandless*, 255 F.3d 465 (7<sup>th</sup> Cir. 2001). As with weighing medical opinion evidence, the fact finder should consider the qualifications of the physicians in reviewing the autopsy evidence of record. *Livermore v. Amax Coal Co.*, 297 F.3d 668 (7<sup>th</sup> Cir. 2002). The Seventh Circuit, in which these claims originate, holds that it is error to mechanically accord more weight to a prosector's opinion over the opinion of a reviewing pathologist. *McCandless, supra* (stating that it is incumbent upon an Administrative Law Judge

to use his expertise to evaluate technical evidence and the reasoning presented by the physicians).

Dr. Heidingsfelder, a Forensic Pathologist, performed an autopsy on the Miner on April 26, 2001, and opined that Mr. Clark's lungs showed macroscopic and microscopic evidence of coal workers' pneumoconiosis and emphysema. Noting Dr. Heidingsfelder's credentials, I afford his opinion great weight in support of a finding of coal workers' pneumoconiosis.

Dr. Naeye, a Board-certified Anatomic and Clinical Pathologist, after review of autopsy slides and medical records, opined that "the many anthracotic macules, micronodules and macronodules in this man's lungs are conclusive evidence of the presence of simple coal workers' pneumoconiosis." Noting Dr. Naeye's superior credentials, I give his opinion substantial weight.

Based on the autopsy reports of Drs. Heidingsfelder and Naeye, I find that the existence of coal workers' pneumoconiosis is established through autopsy evidence pursuant to § 718.202(a)(2).

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of the several presumptions are found to be applicable. In the instant case, § 718.304 does not apply because there is no x-ray, biopsy, autopsy, or other evidence of large opacities or massive lesions in the lungs. Section 718.305 is not applicable to claims filed after January 1, 1982. Section 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982.

Under § 718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Pneumoconiosis is defined in § 718.201 as a chronic dust disease of the lung, including respiratory or pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.

(1) *Clinical Pneumoconiosis*. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine

employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis.* 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

For a physician's opinion to be accorded probative value, it must be well reasoned and based upon objective medical evidence. An opinion is reasoned when it contains underlying documentation adequate to support the physician's conclusions. See *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which the diagnosis is based. *Id.* A brief and conclusory medical report which lacks supporting evidence may be discredited. See *Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); see also, *Mosely v. Peabody Coal Co.*, 769 F.2d 357 (6<sup>th</sup> Cir. 1985). Further, a medical report may be rejected as unreasoned where the physician fails to explain how his findings support his diagnosis. See *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

All physicians who were deposed or examined the record after Mr. Clark's autopsy acknowledge the existence of simple coal workers' pneumoconiosis on the basis of autopsy findings. All physicians generally agree that the Miner suffered from emphysema, chronic obstructive pulmonary disease, and chronic bronchitis. The medical opinion record varies wildly, however, on the etiology of the Miner's emphysema, chronic obstructive pulmonary disease, and chronic bronchitis. It is the existence and impact of legal pneumoconiosis that is the real dispute in this case.

Dr. Carandang, a Board-certified Internist, based his diagnosis on symptomatology, employment history, smoking history, family and individual medical histories, physical examination, chest x-ray, pulmonary function study, and arterial blood gas study. Dr. Carandang diagnosed coal workers' pneumoconiosis based upon a positive x-ray, coal dust exposure

history, symptoms, and physical examination results. An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). Dr. Carandang based his coal workers' pneumoconiosis diagnosis on these objective, permissible items, and I find this diagnosis to be well documented and well reasoned. Noting Dr. Carandang's credentials as an Internist, I give his opinion great weight in support of a finding of clinical pneumoconiosis.

He also diagnosed COPD and listed the etiology as cigarette smoking. He does not discuss the basis of his COPD diagnosis nor does he explain why cigarette smoking caused the ailment. As such, his COPD diagnosis is undocumented, conclusory, and it offers no support towards a possible finding of legal pneumoconiosis.

Dr. Cohen, a Board-certified Internist, Pulmonologist, Critical Care Specialist, Medical Examiner, and B reader, opined that Mr. Clark suffered from both clinical and legal pneumoconiosis. He based his clinical pneumoconiosis diagnosis on a long history of coal dust exposure, symptomatology, physical examination findings (which included wheezes, rales, crackles, and rhonci), pulmonary function results, and autopsy findings. Dr. Cohen's clinical pneumoconiosis diagnosis is well reasoned. His opinion is based upon objective evidence and he explains the basis of his diagnosis. Noting his superior credentials, I give his clinical pneumoconiosis diagnosis substantial weight.

Dr. Cohen also diagnosed the presence of moderate obstructive lung disease with severe diffusion impairment, resulting from an extensive coal dust exposure history and tobacco smoke. He based his legal pneumoconiosis diagnosis on work histories, physical examination results, pulmonary function testing, and a lack of other significant occupational exposures. He discussed an extensive list of medical research and literature supporting the connection between coal mine dust exposure and pulmonary obstruction. Dr. Cohen's legal pneumoconiosis diagnosis is well reasoned. He based his opinion on objective information, explained his reasoning, and supported his findings with extensive medical research and literature.

The Employer argues that Dr. Cohen should be accorded less weight than Peabody's experts because the Employer's experts have "decade's worth of experience as clinicians treating coal miners in their private practice." (Employer's brief at 57)

(original emphasis). Claimant touts Dr. Cohen's experience running the Black Lung Clinics Program at Cook County, as Medical Director of the National Coalition of Black Lung and Respiratory Disease Clinics, as HHS' primary consultant and reviewer of the various clinics in the Federal Government's Black Lung Clinic system, as Course Director for NIOSH's spirometry course, and his experience as a consultant on coal mine health issues for the U.S. Mine Safety and Health Administration, the National Institutes of Health, the U.S. Agency for International Development, and the United Mine Workers (Claimant's brief at 11). Each of the Employer's experts will be evaluated on the basis of their own credentials. The record is clear that Dr. Cohen is Board certified in many relevant areas and that he is considered an expert with extensive experience in occupational lung diseases. Noting Dr. Cohen's extensive and impressive resume, I give his opinion substantial weight supporting both clinical and legal pneumoconiosis.

Dr. Parker, a Board-certified Internist, Pulmonologist, Medical Examiner, and B reader, opined that Mr. Clark suffered from both clinical and legal pneumoconiosis. He based his pneumoconiosis diagnoses (CWP and COPD) on physical examination results, radiographic evidence, pulmonary function testing, and autopsy results. He opined that Mr. Clark's pneumoconiosis and COPD were the result of coal dust exposure and tobacco smoke exposure. In support of his coal dust-induced COPD diagnosis, Dr. Parker reviewed and explained several articles containing research establishing the link between coal dust and COPD and documenting an excess of COPD cases in coal miners versus the general public. He acknowledged the relationship between smoking and COPD and opined that "in Mr. Clark's case we have a substantial history of both [cigarette smoke and coal dust] assaults upon his lungs."

Dr. Parker's opinion is well reasoned. He bases his diagnoses on objective evidence and supports his findings with explanation and with reference to extensive medical literature and research. Noting Dr. Parker's superior credentials, I give his opinion substantial weight in support of both clinical and legal pneumoconiosis.

Dr. Renn, a Board-certified Internist, Pulmonologist, Forensic Examiner, a Forensic Medicine Specialist, and a B reader, submitted two written reports and was deposed by the Employer. As new autopsy evidence was submitted for review, Dr. Renn amended his diagnosis to include simple coal workers' pneumoconiosis based upon autopsy findings.

Dr. Renn also diagnosed chronic bronchitis and pulmonary emphysema "owing to [Mr. Clark's] years of tobacco smoking." A pulmonary disease may constitute statutory pneumoconiosis if it is significantly related to or aggravated by coal mine employment. Asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). In *Hughes v. Clinchfield Coal Co.*, 21 B.L.R. 1-134, 1-139 (1999), the Board specifically held that chronic bronchitis and emphysema fall within the definition of pneumoconiosis if they are related to the claimant's coal mine employment.

In two separate submissions, Dr. Renn quoted a smoking history of 60 pack years (LM EX 6, 8). It is proper for an ALJ to discredit a medical opinion based on an inaccurate smoking history. *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993). In this case, I have found a smoking history approximating 15 pack years.

Dr. Renn overstated the Miner's smoking history and failed to adequately document why smoking, which ceased in 1966, was the only etiology possible when the Miner had 35 years of coal dust exposure ending in 1982. He further failed to explain why 35 years of coal dust exposure did not aggravate the Miner's pulmonary condition. As such, his bronchitis and emphysema analysis is unsupported and inadequately unreasoned.

I find Dr. Renn's coal workers' pneumoconiosis diagnosis to be well reasoned and based upon objective evidence, namely, the Miner's autopsy. Noting Dr. Renn's superior credentials, I give his coal workers' pneumoconiosis diagnosis great weight. Dr. Renn's chronic bronchitis and emphysema diagnoses are inadequately reasoned and do not support a possible finding of legal or statutory pneumoconiosis.

Dr. Repsher, a Board-certified Internist, Pulmonologist, Medical Examiner, Critical Care Specialist, and B reader, submitted two reports and was deposed by the Employer. He opined that review of later submitted autopsy reports demonstrated the existence of simple coal workers' pneumoconiosis.

He opined that the Miner suffered from moderate to moderately severe COPD and emphysema secondary to cigarette smoke. In explaining his etiology findings, he opined that "none of these conditions [COPD and emphysema] have ever been related to work in a coal mine." (LM EX 5, p. 4). Chronic

obstructive lung disease is encompassed into the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4<sup>th</sup> Cir. 1995). Emphysema is also considered part of the legal form of pneumoconiosis if related to coal dust exposure. *Hughes, Robinson, supra*. The Seventh Circuit permits "an ALJ to disregard medical testimony when a physician's testimony is affected by his subjective personal opinions about pneumoconiosis which are contrary to the congressional determinations implicit in the Act's provisions." *Midland Coal Co. v. Director, OWCP*, 358 F.3d 486, 491 (7<sup>th</sup> Cir. 2004).

While Dr. Repsher's opinion does not rise to the level of "hostile to the Act," he fails to adequately explain why coal dust could not cause, contribute, or aggravate the Miner's COPD and emphysema and he does not adequately document or explain why smoking is the only etiology of the Miner's pulmonary impairments. Dr. Repsher spent more time trying to debunk the medical literature relied upon by Dr. Cohen than he did in explaining his own diagnoses.

Noting Dr. Repsher's superior credentials, I find that his clinical pneumoconiosis is based upon objective evidence, namely the autopsy reports, and I give that opinion substantial weight. I find Dr. Repsher's diagnoses of COPD and emphysema due to cigarette smoking to be inadequately reasoned.

Dr. Selby, a Board-certified Internist, Pulmonologist, Critical Care Specialist, and B reader, examined the Miner in 1999, and opined that there was no objective evidence of coal workers' pneumoconiosis or any pulmonary or respiratory abnormality as a result of coal mine employment. He based his opinion on negative x-rays, CT scans, and on his physical examination.

Dr. Selby's negative clinical pneumoconiosis diagnosis is based on incomplete information. Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (*en banc*); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986); *Old Ben Coal Co. v. Scott*, 144 F.3d 1045 (7<sup>th</sup> Cir. 1998). Dr. Selby's examination was in 1999, two years before the Miner died and before the autopsy evidence was available for review. An opinion may be given less weight where the physician did not have a complete picture of the miner's condition. *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986). Every physician of record has acknowledged the existence of simple coal workers' pneumoconiosis when presented with the Miner's autopsy reports. Dr. Selby did not have access to these reports. I find

Dr. Selby's coal workers' pneumoconiosis diagnosis to be based upon incomplete information, and it is given less weight.

Dr. Selby also diagnosed moderate obstructive lung defect as a result of cigarette smoking with a possible bronchial asthma component. He based his smoking etiology on the Miner's self-reported "history" and by the partial reversibility shown by bronchodilation. Dr. Selby recorded only a 6-12 pack year history of smoking, ending no later than age 58. He noted over 30 years of coal mine employment, ending in the 1980's. Dr. Selby failed to adequately support his smoking etiology. His etiology opinion is based, in part, upon subjective evidence; that is, the Miner's self-reported smoking history, which Dr. Selby's acknowledges was "extremely vague and difficult to understand." Dr. Selby also relied on the partially bronchoreversible nature of the obstructive defect. Dr. Cohen effectively explained that the Miner's pulmonary function was only slightly reversible and that his FEV<sub>1</sub> rating was still substantially reduced after bronchodilation.

Finally, Dr. Selby diagnosed chronic bronchitis by history, and opined that the bronchitis was unrelated to coal mine employment because the cough has progressed unabated for the last 20-25 years, long after his last coal dust exposure. This diagnosis suffers from multiple flaws. First it is based on subjective evidence, namely the Miner's self-reported history of bronchitis. Second, Dr. Selby dismissed coal dust as an etiology but offered no alternative to explain the bronchitis and its symptoms. Third, while he discounted coal dust because the Miner had long since been removed from the source of exposure, he failed to explain how cigarette smoke may have impacted the bronchitis, given that he quit smoking over a decade before he left the coal mines.

I find Dr. Selby's opinion to be either unreasoned or based upon incomplete information and it is given less weight.

Dr. Tuteur, a Board-certified Internist and Pulmonologist, opined, after review of autopsy records, that the Miner suffered from simple coal workers' pneumoconiosis. He stated that x-rays, symptomatology, physical examination reports, pulmonary function testing, and CT scans all supported the existence of emphysema and advanced chronic obstructive pulmonary disease. He opined that the COPD and emphysema were due to cigarette smoking alone. He cited medical literature and research suggesting that the Miner's risk of contracting coal-related COPD with his exposure conditions was less than 1%. He disagreed with the findings of Drs. Cohen and Parker.

As with the other physicians of record, Dr. Tuteur adjusted his diagnosis to confirm the existence of simple coal workers' pneumoconiosis after review of autopsy reports. He supported his smoking etiology with objective data and with medical literature which explains objective test results in relation to etiology of the Miner's COPD and emphysema. Given Dr. Tuteur's superior credentials, I give his opinion great weight in support of a finding of simple coal workers' pneumoconiosis.

Drs. Wiot, Perme, Meyer, Shipley, and Spitz, all Board-certified Radiologists and B readers, interpreted the September 30, 1999, CT scan as negative. Dr. Schultheis, who presents no radiographic specialty credentials, also found the CT scan to be negative. The Department of Labor has rejected the view that a CT scan, by itself, "is sufficiently reliable that a negative result effectively rules out the existence of pneumoconiosis." 65 Fed. Reg. 79, 920, 79, 945 (Dec. 20, 2000). Therefore, a CT scan, while arguably the most sophisticated and sensitive test available must still be measured and weighed based on the radiological qualifications of the reviewing physician. *Consolidation Coal Co. v. Director, OWCP [Stein]*, 294 F.3d 885 (7<sup>th</sup> Cir. 2002). Given the long list of dually certified physicians interpreting this CT scan, I find that the September 30, 1999, CT scan weighs against a finding of clinical coal workers' pneumoconiosis. As described throughout, however, the autopsy evidence demonstrates the existence of coal workers' pneumoconiosis in spite of negative reading of this scan.

Dr. Nehren, the Miner's family physician and a Board-certified Family Practitioner, opined that the Miner suffered from "severely restricted and obstructed lung disease, COPD exacerbated by a history of black lung disease." Dr. Nehren's opinion is factually flawed and not well reasoned. As pointed out by numerous physicians of record, the objective data does not show the Miner suffered from a restrictive defect. The Miner was never proven to be oxygen dependent as shown by arterial blood gas readings. The testing does not support a finding of hypoxia. There was no "history" of black lung documented for Dr. Nehren to rely on. Dr. Nehren makes no mention of nor does she incorporate the Miner's employment history or smoking history into her diagnosis. As such, the report is factually flawed, incomplete, unsupported, and unreasoned.

"Treating physicians often succumb to the temptation to accommodate their patients (and their survivors) at the expense of third parties such as insurers, which implies attaching a discount rather than a preference to their views." *Peabody Coal Co. v. McCandless*, 255 F.3d 465 (7<sup>th</sup> Cir. 2001). A report which

is seriously flawed may be discredited. *Goss v. Eastern Assoc. Coal Corp.*, 7 B.L.R. 1-400 (1984). Noting Dr. Nehren's lack of pulmonary specialty credentials, the factual flaws found in her report, and the Seventh Circuit's preference for not mechanically according greater weight to a treating physician without review of the reasoning behind her opinion, I give Dr. Nehren's opinion less weight.

The Miner's Certificate of Death lists "black lung" and "COPD" as contributing causes of death. A death certificate, in and of itself, is an unreliable report of the miner's condition where the record provides no indication that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. *Smith v. Camco Mining, Inc.*, 13 B.L.R. 1-17 (1989); *Addison v. Director, OWCP*, 11 B.L.R. 1-68 (1988). A death certificate stating that pneumoconiosis contributed to the miner's death, without some further explanation, therefore, is insufficient to prove the existence of coal workers' pneumoconiosis. *Bill Branch Coal Co. v. Sparks*, 213 F.3d 186 (4<sup>th</sup> Cir. 2000). The Death Certificate was completed by Dr. DuPre, one of the Miner's treating physicians. As such, he was aware of the Miner's personal medical history. Dr. DuPre lists no pulmonary specialty credentials in the record.

As the autopsy reports confirm the existence of simple coal workers' pneumoconiosis and as Drs. Carandang, Cohen, Parker, Repsher, and Selby opined that the Miner suffered from COPD (with differing etiologies), I find that the Death Certificate supports the existence of coal workers' pneumoconiosis and COPD.

Treatment notes sporadically record a "history" of black lung disease without formal diagnosis of the disease through objective testing. Treatment notes from Dr. Rohrer, who presents no specialty medical credentials, routinely diagnose COPD and emphysema without naming an etiology. I find that the treatment notes and hospitalization records generally corroborate the existence of COPD and emphysema, but do not tie the disease to coal mine employment.

After review of the autopsy reports, Drs. Cohen, Parker, Renn, Repsher, and Tuteur all opined that the Miner suffered from simple clinical coal workers' pneumoconiosis. The CT scans, while overwhelmingly negative, are outweighed by the autopsy evidence and the interpreting opinions of the above listed physicians. Accordingly, I find that the Claimant has established the existence of clinical pneumoconiosis under § 718.202(a)(4).

Dr. Cohen and Dr. Parker, Pulmonary Specialists, provide well-reasoned opinions, based upon objective medical evidence, that the Miner also suffered from legal pneumoconiosis as defined in § 718.201. The record is filled with extensive reference to medical literature, interpretation of the studies cited, and conclusions drawn by various physicians. Attacks were made on the medical literature by all parties in such areas as the age of the study, the methodology used, the location of the miners studied, the drop out rate, the incorporation of smoking habits into the study, and many other criteria. After careful review of all arguments presented and opinions rendered, I am most persuaded by the reports and supporting medical literature of Dr. Cohen and Dr. Parker. The report of Dr. Tuteur, while also well reasoned, is less persuasive than the reasoning provided by Dr. Cohen. The Death Certificate provides corroborating support for the existence of coal workers' pneumoconiosis and COPD. The treatment records generally corroborate the existence of COPD and emphysema. The opinions of Drs. Carandang, Renn, Repsher, Selby, and Nehren are not well reasoned. Accordingly, I find that the Claimant has established the existence of legal pneumoconiosis under § 718.202(a)(4).

#### Causal Connection Between Pneumoconiosis and Coal Mine Work

The Claimant must establish that the Miner's pneumoconiosis arose, at least in part out of coal mine employment. § 718.203(a). It is presumed that the pneumoconiosis of a miner who establishes 10 or more years of coal mine employment arose out of coal mine employment. *Id.* Thirty-five years of coal mine employment have been established. I find that the Miner's coal workers' pneumoconiosis arose out of coal mine employment. Further, a finding of legal pneumoconiosis, by definition, requires a finding of pulmonary disease arising out of coal mine employment. Section 718.201(a)(2). Having found the existence of legal pneumoconiosis, I find that the Miner's legal and clinical pneumoconiosis arose out of coal mine employment.

#### Total Disability

Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. Section 718.204(b)(1)(i) and (ii). The Claimant must establish by a preponderance of the evidence that the miner's pneumoconiosis was at least a contributing cause of his total disability. See, e.g., *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4<sup>th</sup> Cir. 1994).

Total disability can be established pursuant to one of the four standards in § 718.204(b)(2) or through the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b)(1). The presumption is not invoked here because there is no x-ray evidence of large opacities and no biopsy or equivalent evidence.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in § 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under § 718.204(c), the precursor to § 718.204(b)(2), all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987).

Section 718.204(b)(2)(i) permits a finding of total disability when there are pulmonary function studies with FEV<sub>1</sub> values equal to or less than those listed in the tables and either:

1. FVC values equal to or below listed table values; or,
2. MVV values equal to or below listed table values; or,
3. A percentage of 55 or less when the FEV<sub>1</sub> test results are divided by the FVC test results.

The record contains two pulmonary function studies. Employer concedes that Mr. Clark's values, at age 83, meet the disability requirements of a miner who was 71 years old (the last table value), but argues that reliance on the chart values fails to consider the physiologic fact that pulmonary capacity is lost by age alone (Employer's brief at 72). I find that the pulmonary function testing supports total disability and will consider the Employer's argument that any disability shown by pulmonary function testing is strictly a product of age and not as a result of the effects of pneumoconiosis when reviewing disability etiology.

Total disability may be found under § 718.204(b)(2)(ii) if there are arterial blood gas studies with results equal to or less than those contained in the tables. The record contains two arterial blood gas studies. Drs. Tuteur and Renn opined that the Miner's pO<sub>2</sub> reading at rest on the March 30, 1999, test was invalid and artificially high in that such a reading reflected that the Miner's body actually expelled oxygen rather than absorbed it. Based on the invalidations of Drs. Tuteur and Renn, and with no contradictory opinion, I find that the resting

portion of Dr. Carandang's March 30, 1999, test is nonconforming and invalid, and I afford it no probative weight. The remaining arterial blood gas testing results are nonqualifying.

There is no evidence presented that Claimant suffers from cor pulmonale or complicated coal workers' pneumoconiosis.

Under § 718.204(b)(2)(iv) total disability may be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work.

Dr. Carandang, a Board-certified Internist, opined that the Miner could no longer perform his last mining job. He did not compare the exertional requirements of Mr. Clark's job as a Mine Inspector against his pulmonary capacity on examination. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6<sup>th</sup> Cir. 2000); *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993); *Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990) (*en banc* on recon.). He did not list the basis of his disability opinion or discuss the etiology of the Miner's total disability. A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182 (1984). A report which is seriously flawed may also be discredited. *Goss v. Eastern Assoc. Coal Corp.*, 7 B.L.R. 1-400 (1984). Dr. Carandang took a chest x-ray of the Claimant, but the x-ray noted on the report is not part of the record and no interpretation of that x-ray is listed in Dr. Carandang's opinion. He documents an arterial blood gas study which Drs. Renn and Tuteur found to be nonconforming and invalid. Given Dr. Carandang's failure to list the basis of his opinion, his failure to provide an etiology for the total disability diagnosed, his failure to compare the exertional requirements of the Miner's last job as a Mine Inspector against the Claimant's pulmonary capacities, his use of an x-ray not in the record and his use of an invalid arterial blood gas study, I find Dr. Carandang's opinion is flawed, unsupported, and unreasoned, and I give it less weight.

Dr. Cohen, a Board-certified Internist, Pulmonologist, Critical Care Specialist, Medical Examiner, and a B reader, opined that reduced pulmonary function readings and physical examination findings showed that the Miner's chronic obstructive pulmonary disease was totally disabling. He compared the Miner's reduced pulmonary ability against the requirements of Mr. Clark's last job as a mine inspector. He opined that Mr. Clark was no longer capable of carrying a 30-pound tool belt

while walking and occasionally crawling through coal mines. Dr. Cohen's opinion is well reasoned. He utilized the objective evidence and then compared the Miner's current pulmonary capacity against the requirements of his last coal mine job. Noting Dr. Cohen's superior credentials, I give his opinion great weight.

Dr. Parker, a Board-certified Internist, Pulmonologist, Medical Examiner, and B reader, opined that Mr. Clark was totally disabled from resuming his last coal mine position as a mine inspector. He based his opinion on physical examination results and reduced pulmonary function readings. He compared Mr. Clark's reduced pulmonary capacity against the requirements of a mine inspector, which included carrying a 30-pound tool belt while walking on uneven terrain in coal mines. Dr. Parker's opinion is well reasoned. He based his evaluation of the Miner's pulmonary ability on objective evidence and then compared the reduced capacity against the Miner's last coal mine position. Noting Dr. Parker's superior credentials, I afford his opinion great weight.

Dr. Renn, a Board-certified Internist, Pulmonologist, Forensic Examiner, Forensic Medicine Specialist, and B reader, opined that the Miner was totally disabled from performing his last job as a coal mine inspector due to chronic bronchitis and pulmonary emphysema. He based his opinion on pulmonary function testing showing a moderate obstructive defect and exercise arterial blood gases showing impairment in gas exchange. Dr. Renn's opinion is well reasoned. He based his disability findings on objective testing. Noting his superior credentials, I give his opinion great weight.

Dr. Repsher, a Board-certified Internist, Pulmonologist, Medical Examiner, Critical Care Specialist, and B reader, opined that Mr. Clark's COPD would have made him uncomfortable, but that "he certainly had plenty of lung function even in 1999 that he could have done light work and certainly a desk job." He characterized Mr. Clark's position as Chief Coal Mine Inspector for the State of Indiana as "pretty much a desk job with only occasionally going out in the field." The Administrative Law Judge, as the fact-finder, is required to compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6<sup>th</sup> Cir. 2000); *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993); *Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990) (*en banc* on recon.). A reasoned opinion is one in which the Administrative Law Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*,

10 B.L.R. 1-19 (1987). A report which is seriously flawed may be discredited. *Goss v. Eastern Assoc. Coal Corp.*, 7 B.L.R. 1-400 (1984). Dr. Repsher inaccurately portrayed Mr. Clark's job as an inspector as primarily a "desk job" when the record reflects that the job regularly required work in and around coal mines, walking on uneven terrain, while wearing a 30-pound tool belt. As Dr. Repsher did not accurately consider the exertional requirements of Mr. Clark's usual coal mine employment, his opinion is not well reasoned. I afford his opinion less weight.

Dr. Selby, a Board-certified Internist, Pulmonologist, Critical Care Specialist, and B reader, opined that Mr. Clark was not totally disabled and that he retained the respiratory capacity to perform his previous positions as a superintendent, unit foreman, or as a mine inspector. Dr. Selby based his diagnosis on physical examination, pulmonary function, and arterial blood gas testing. Dr. Selby's opinion is well reasoned. He based his opinion on objective evidence, weighing a normal physical examination and normal arterial blood gases against the Miner's moderate obstructive defect, and opined that he could still perform his previous jobs. Noting Dr. Selby's superior credentials, I give his opinion great weight.

Dr. Tuteur, a Board-certified Internist and Pulmonologist, opined that pulmonary function studies showed a moderate obstructive ventilatory defect and impairment of gas exchange during exercise, which would prevent Mr. Clark from performing the work of a coal miner or work requiring similar effort. Dr. Tuteur's opinion is well reasoned. He based his disability finding on objective evidence and supported his diagnosis. Noting Dr. Tuteur's superior credentials, I give his opinion great weight.

Dr. Naeye, a Board-certified Anatomic and Clinical Pathologist, opined that microscopic review of autopsy slides and a review of the Miner's records showed that Mr. Clark's coal workers' pneumoconiosis was too mild to have caused disability, and that the Miner was totally disabled by emphysema and chronic bronchitis. He did not tie the Miner's emphysema and bronchitis to coal mine employment, and he opined that the Miner's disability was solely due to smoking.

It is proper for the Administrative Law Judge to accord less weight to a physician's opinion that is based on premises contrary to the Judge's findings. *Amax Coal Co. v. Director, OWCP [Chubb]*, 312 F.3d 882 (7<sup>th</sup> Cir. 2002) (holding that the ALJ properly discredited medical opinion that pneumoconiosis did not contribute to the miner's total disability because the physician's opinion was based on a finding that the miner did

not suffer from the disease contrary to the ALJ's findings). Dr. Naeye did not diagnose legal pneumoconiosis, contrary to my finding that the Miner's emphysema and bronchitis were consistent with the statutory form of pneumoconiosis.

Dr. Naeye did not address the Miner's qualifying pulmonary function results. He did not measure the exertional requirements of Mr. Clark's last coal mine employment as an Inspector against his pulmonary capacity at the time of death. *Cornett, supra*. He did not explain how the coal workers' pneumoconiosis viewed on the autopsy slides was "too mild" to have caused disability.

A reasoned opinion is one in which the Administrative Law Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989 (*en banc*)). I find Dr. Naeye's documentation and data inadequate to support his conclusion that the Miner was disabled only by smoking. I give his opinion less weight.

Drs. Wiot, Perme, Meyer, Schultheis, Shipley, and Spitz reviewed CT scans and did not offer a disability diagnosis. Dr. Heidingsfelder performed the Miner's autopsy and, likewise, offered no disability opinion. Dr. Nehren offered a pneumoconiosis diagnosis and an opinion on cause of death, but did not make a total disability determination. Their opinions are accorded little probative weight in making a determination of total pulmonary disability.

Drs. Cohen, Parker, Renn, and Tuteur, all Pulmonary Specialists, offer well-reasoned opinions, based upon objective evidence that the Miner suffers from total pulmonary disability. While Drs. Renn and Tuteur opine that the disability is due to cigarette smoking, I have held the Miner's chronic bronchitis and emphysema to be a form of legal pneumoconiosis caused by coal mine employment. Dr. Selby, also a Pulmonary Specialist, offers a well-reasoned opinion that the Miner does not suffer from total pulmonary disability. Drs. Carandang, Repsher, and Naeye offer unreasoned opinions on the issue of total disability.

Pulmonary function testing produced qualifying values. While I acknowledge the Employer's argument that age is a factor in reviewing the qualifying numbers, I find that the pulmonary function evidence is supportive of total disability. Arterial blood gas testing was nonqualifying.

When reviewed as a whole, the qualifying pulmonary testing, nonqualifying blood gas testing, and the well-reasoned opinions of Drs. Cohen, Parker, Renn, and Tuteur that Mr. Clark suffered total pulmonary or respiratory disability, demonstrate that the Miner was totally disabled due to legal pneumoconiosis under § 718.204(b)(2). Dr. Selby's contrary opinion, while well reasoned, is outweighed by the majority of well-reasoned opinions by similarly qualified physicians. I find that the evidence establishes that the Miner was totally disabled due to pneumoconiosis arising out of coal mine employment. The Employer has failed to demonstrate a mistake in determination of fact.

#### Survivor's Claim

Section 718.205 provides that benefits are available to eligible survivors of a miner whose death was due to pneumoconiosis. In order to receive benefits, the Claimant must prove that:

The Miner had pneumoconiosis (see § 718.202).

The Miner's pneumoconiosis arose out of coal mine employment (see § 718.203); and,

The Miner's death was due to pneumoconiosis as provided by this section.

20 C.F.R. § 718.205(a).

As discussed in detail above, I have found that Mr. Clark suffered from both clinical and legal pneumoconiosis arising out of coal mine employment. The record will now be reviewed to determine whether Mr. Clark's death was due to pneumoconiosis.

Under § 718.205(c), a claimant may establish death due to pneumoconiosis in any of the following circumstances: (1) where competent medical evidence establishes that the miner's death was due to pneumoconiosis; (2) where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis; or, (3) where the presumptions set forth at § 718.304 is applicable. As no evidence of complicated pneumoconiosis has been presented, I find that the presumptions of § 718.304 are not applicable to this claim. Under the Seventh Circuit, any condition that hastens the miner's death is a substantially contributing cause of death for purposes of § 718.205. *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178 (7<sup>th</sup> Cir. 1992).

The record contains the Death Certificate and numerous medical narratives. For a physician's opinion to be accorded probative value, it must be well reasoned and based upon objective medical evidence. An opinion is reasoned when it contains underlying documentation adequate to support the physician's conclusions. See *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which the diagnosis is based. *Id.* A brief and conclusory medical report which lacks supporting evidence may be discredited. See *Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); see also, *Mosely v. Peabody Coal Co.*, 769 F.2d 357 (6<sup>th</sup> Cir. 1985). Further, a medical report may be rejected as unreasoned where the physician fails to explain how his findings support his diagnosis. See *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

The opinions of Drs. Carandang, Cohen, Parker, Repsher, Selby, Wiot, Perme, Meyer, Schultheis, Shipley, and Spitz do not address the cause of the Miner's death. An opinion which is silent as to an issue is not probative of that issue. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4<sup>th</sup> Cir. 2000). As these reports offer no opinion on cause of death, they are given no probative weight on causation of death under § 718.205.

Dr. Renn opined that Mr. Clark died of overlapping cardiac and artery problems complicated by malnutrition and gangrene. He stated that the Miner's clinical and legal pneumoconiosis did not cause of hasten his death. He based his opinion on review of autopsy reports and on review of hospitalization and treatment notes associated with the Miner's last illness and hospitalizations. Dr. Renn's report is well reasoned. He based his opinion on objective autopsy evidence and supported his findings with hospitalization records showing no pulmonary problems associated with the Miner's last four hospitalizations before death. Noting Dr. Renn's superior credentials, I give his opinion great weight.

Dr. Tuteur reviewed the autopsy records and reports and hospitalization records and opined that:

Mr. Ralph E. Clark died with and because of complications of arteriosclerotic heart disease, atrial fibrillation, congestive heart failure, peripheral vascular disease, and the acute development of gangrene, osteomyelitis, and renal failure, all leading to death. None of these conditions are in any way related to, aggravated by, or caused by the

inhalation of coal mine dust or the development of coal workers' pneumoconiosis.

Dr. Tuteur's opinion is well reasoned. He bases his opinion on objective evidence and supports his diagnosis with hospitalization records. Noting his superior credentials, I afford his opinion great weight.

Dr. Nehren, the Miner's family physician, opined that:

His severe lung restriction secondary to chronic pulmonary disease ... significantly aggravated the conditions from which he died including his chronic hypoxia and O<sub>2</sub> dependent, acute vascular disease and malnutrition experienced during his hospital stay as well as his ability to recover from pulmonary assault. I believe that the pneumoconiosis was a substantial re-contributing factor to this man's death although it does not appear to have been the direct cause.

Dr. Nehren's opinion is not well reasoned. As stated in detail above, many physicians found Dr. Nehren's report to be factually flawed in that the Miner did not suffer from chronic hypoxia, was never objectively determined to be O<sub>2</sub> dependent, and was not shown to be suffering from "pulmonary assault" during his last four hospitalizations. Dr. Nehren is neither a Pulmonary Specialist nor a Pathologist, and Dr. Nehren does not list the basis for her findings. Noting her lack of specialty medical credentials, the factual flaws contained in her report, and the conclusory nature of her opinion, I afford Dr. Nehren's report less weight.

The Indiana Certificate of Death lists the immediate cause of death as malnutrition, due to or as a consequence of "black lung, COPD, inability to swallow." Other significant conditions contributing to death are illegible. The Certificate of Death was filled out by Dr. DuPre, one of the Miner's treating physicians. A death certificate, in and of itself, is an unreliable report of the miner's condition where the record provides no indication that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. *Smith v. Camco Mining, Inc.*, 13 B.L.R. 1-17 (1989); *Addison v. Director, OWCP*, 11 B.L.R. 1-68 (1988). Dr. DuPre, who presents no medical specialty credentials, was one of the Miner's treating physicians. While Dr. DuPre treated the Miner, he apparently did not have access to the hospitalization records for the Miner's last illnesses or to the autopsy evidence. The hospitalization records do not reference any respiratory or

pulmonary conditions nor is black lung or COPD diagnosed or treated in the Miner's last four hospitalizations. Noting Dr. DuPre's lack of specialty credentials, the conclusory nature of the Death Certificate, and his failure to incorporate the Miner's last medical records into his completion of the Death Certificate, I find the Death Certificate to be unreasoned and unreliable in establishing a cause of death due to pneumoconiosis.

Dr. Heidingsfelder, a Forensic Pathologist, performed the Miner's autopsy. He performed a macroscopic and microscopic review and noted 16 different ailments suffered by the Miner, but he did not make a cause of death determination. As such, his opinion offers no support for a finding of death due to pneumoconiosis.

Dr. Naeye reviewed the medical records, including the autopsy report, and personally reviewed 23 autopsy slides. He opined that coal workers' pneumoconiosis was too mild to have had a significant role in the Miner's death. He did not list an alternative cause of death. Dr. Naeye based his opinion on personal review of the autopsy slides. Noting his superior credentials as a Board-certified Pathologist, I give his opinion great weight in support of a finding that coal workers' pneumoconiosis did not hasten the Miner's death. Dr. Naeye does not address whether legal pneumoconiosis in the form of emphysema and chronic bronchitis hastened the Miner's death.

Hospitalization records of the Miner's last illnesses do not document pneumoconiosis, black lung, COPD, or any other pulmonary impairment. They document arteriosclerotic heart disease, atrial fibrillation, congestive heart failure, peripheral vascular disease, and the acute development of gangrene, osteomyelitis, and renal failure. As such, they lend no support to the Claimant.

The Claimant has the burden of proving every element of entitlement, by a preponderance of the evidence. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Drs. Renn and Tuteur, both Pulmonary Specialists, offer well-reasoned opinions, based upon objective evidence, that the Miner's death was not hastened by his pneumoconiosis. This finding is corroborated by the opinion of Dr. Naeye, a Board-certified Pathologist, and by the hospitalization records. The Death Certificate has been found unreliable, and Dr. Nehren's opinion is not well reasoned. Mrs. Clark has not established that the Miner's death was hastened by pneumoconiosis under § 718.205. As such, her claim must fail.

## VI. Entitlement

Ralph E. Clark, the Miner, has established entitlement to benefits under the Act. As the month of onset of total disability due to pneumoconiosis cannot be deduced from the medical evidence of record, benefits are to be paid from the month during which the claim was filed, or February 1999. Twenty C.F.R. § 725.503(b) (2000) and (2001); *Owens v. Jewell Smokeless Coal Corp.*, 14 B.L.R. 1-47 (1990). Under § 725.203(b)(1), benefits are payable until the month before the month during which the Miner died, or March 2001.

Katie Lucille Clark, the Widow, has not established entitlement to benefits under the Act.

## VII. Attorney's Fee

No award of attorney's fees for services to the Claimant is made herein because no application has been received from counsel. A period of 30 days is hereby allowed for Claimant's counsel to submit an application. *Bankes v. Director*, 8 B.L.R. 2-1 (1985). The application must conform to 20 C.F.R. §§ 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a Service Sheet showing that service has been made upon all parties, including the Claimant and the Solicitor as counsel for the Director. Parties so served shall have 20 days following receipt of any such application within which to file their objections. Failure to timely file objections will be taken as concurrence in the fee petition. Counsel is forbidden by law to charge the Claimant any fee in the absence of the approval of such application.

## VIII. ORDER

It is, therefore,

ORDERED that the Employer, Peabody Coal Company, shall:

1. Pay to the Claimant, Katie Clark, all benefits to which the Miner, Ralph Clark, is entitled, commencing in February 1999, the month in which the claim was filed, and ending in March 2001, the month before the month that the Miner died;
2. Pay to the Black Lung Disability Trust Fund reimbursement for any payment the Fund has made to Ralph E. Clark under the Act, and to deduct such

amounts, as appropriate, from the amount the Employer is Ordered to pay under paragraph 1 above;

3. Pay to the Black Lung Disability Trust Fund interest as provided by law under § 6621 of the Internal Revenue Code of 1954. Interest is to accrue thirty (30) days from the date of the initial determination of entitlement to benefits. Twenty C.F.R. § 725.609;
4. Pay to the Claimant's attorney, Thomas E. Johnson, fees and expenses to be established in a Supplemental Decision and Order; and it is further,

ORDERED that the claim of Katie Lucille Clark, Widow of Ralph E. Clark, for benefits under the Act is hereby DENIED.

A

Robert L. Hillyard  
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C., 20013-7601. A copy of a Notice of Appeal must also be served upon Donald S. Shire, Esq., 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.